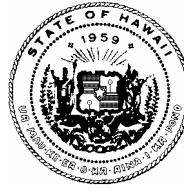


LINDA LINGLE  
GOVERNOR



LILLIAN B. KOLLER, ESQ  
DIRECTOR

HENRY OLIVA  
DEPUTY DIRECTOR

STATE OF HAWAII  
DEPARTMENT OF HUMAN SERVICES  
P. O. Box 339  
Honolulu, Hawaii 96809-0339

**MANDATED REPORTER CHECKLIST  
FOR SUSPECTED CHILD ABUSE AND NEGLECT**

**When reporting to Child Welfare Services (CWS), Child Protective Services (CPS) please:**

1. Review available records.
2. Fill out the checklist as completely as possible using Y for yes, N for no. Leave blank if unknown, unless otherwise indicated.
3. Call the **CWS Intake Reporting Line at (808) 832-5300 or toll free for neighbor islands at 1-800-494-3991** to report your findings.
4. FAX or Mail this document with comments within 5 days to CWS after verbally reporting to the intake worker. **Doing so fulfills your statutory obligation under Chapter 350-1.1(c), Hawaii Revised Statutes, which requires a report in writing as well as the oral report.**
5. If your referral is accepted for investigation, you will be contacted with the disposition.

**To:**  
**Child Welfare Services Intake Unit**  
**420 Waiakamilo Road, Suite 300A**  
**Honolulu, HI 96817-4941**

**Reporting Line: (808) 832-5300 Toll Free Neighbor Islands: 1-800-494-3991**  
**FAX: (808) 832-5292 Toll Free FAX: 1-800-399-1614**

Oral report made to:

Name of Intake Worker: \_\_\_\_\_ Date/time of report: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Police Report # \_\_\_\_\_ Officer Assigned (If applicable) : \_\_\_\_\_

FROM: (Name, Agency and Address of Reporter)	
Name/Agency:	
Address:	Telephone:

ALLEGED VICTIM/S:				
Name	DOB	AGE	School/Grade/SPED	Home Address
1.				
2.				
3.				

ALLEGED MALTREATER/S:	
Name:	Name:
Address:	Address:
Telephone:	Telephone:
Relationship to victim:	Relationship to victim:

Please list other family members (siblings, others living in home, significant kin, etc.)		
Name	DOB	Relationship to Victim
1.		
2.		
3.		
4.		
5.		
6.		

## **FACTORS**

### **1. Location and address of child: (at time of report, please check appropriate block and provide address)**

<input type="checkbox"/>	School	<input type="checkbox"/>	Office
<input type="checkbox"/>	Home	<input type="checkbox"/>	Other: (Specify)
Address:			
			Contact tel:

### **2. Type of harm:**

<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	Threatened physical abuse
<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	Threatened sexual abuse
<input type="checkbox"/>	Physical neglect	<input type="checkbox"/>	Threatened physical neglect
<input type="checkbox"/>	Psychological/emotional abuse	<input type="checkbox"/>	Threatened psychological harm

### **3. Evidence of harm:**

#### **A. Physical:**

a	<input type="checkbox"/>	Bruising, bleeding	i	<input type="checkbox"/>	Subdural hematoma (per medical diagnosis)
b	<input type="checkbox"/>	Injury causing substantial bleeding	j	<input type="checkbox"/>	Soft tissue swelling
c	<input type="checkbox"/>	Malnutrition	k	<input type="checkbox"/>	Extreme pain
d	<input type="checkbox"/>	Failure to thrive	l	<input type="checkbox"/>	Extreme impairment in child's functioning

4. Please describe briefly what happened. Include what the child said and to whom. Include date/time (or approximate month/year) and location of incident. (Use additional sheets as needed)


5. What immediate action do you believe needs to be taken? Briefly comment:


6. Frequency and intensity of harm, if known by reporter:

<input type="checkbox"/>	Single incident	<input type="checkbox"/>	Occurs several times/year, escalating harm
<input type="checkbox"/>	Infrequent incidents, no escalation of harm	<input type="checkbox"/>	Chronic and serious, ongoing pattern of harm

7. Duration of harm, if known by reporter:

<input type="checkbox"/>	No history of harm, no previous incidents	<input type="checkbox"/>	Harm occurs repeatedly over a period of one year
<input type="checkbox"/>	Short duration of harm, less than one month	<input type="checkbox"/>	Harm is chronic

8. Is the reporter aware of any prior reports to CWS involving the child or family?

9. Has the victim expressed any of the following:

a	<input type="checkbox"/>	Fear of caretaker	e	<input type="checkbox"/>	The victim's sibling/s have also been harmed
b	<input type="checkbox"/>	Fear of returning to the family home	f	<input type="checkbox"/>	The harm occurs frequently (self or other)
c	<input type="checkbox"/>	Afraid of being harmed again	g	<input type="checkbox"/>	The harm has gotten worse
d	<input type="checkbox"/>	Harm was reported harm to friend	h	<input type="checkbox"/>	Other

10. Additional concerns regarding the child's health? Explain:

- a. ☐ Mental: \_\_\_\_\_
- b. ☐ Physical: \_\_\_\_\_

#### SERVICES/TREATMENT HISTORY

11. Has the family participated in any service or treatment prior to the report of harm such as:

c		Individual counseling or therapy	h		Parenting classes
d		Anger management	i		Other: Specify below
e		Public Health Nursing			

### **SUPPORT SYSTEM**

**13. Support system available to the child and family, willing and able to assist. Including the following:**

a		Parents	f		Friends
b		Maternal grandparents	g		Church members
c		Paternal grandparents	h		Community groups
d		Siblings	i		Service providers
e		Other relatives	j		Other: specify below

### **FAMILY HISTORY**

**14. Is there a known history of (for mother, father or father figure):**

		<b>MOTHER</b>			<b>FATHER/FATHER FIGURE</b>
a		CWS involvement	g		CWS involvement
b		Domestic violence	h		Domestic violence
c		Substance abuse: (Specify)	i		Substance abuse: (Specify)
d		Mental illness	j		Mental illness
e		Victim of abuse	k		Victim of abuse
f		Perpetrator of abuse	l		Perpetrator of abuse

**Explain "yes" responses briefly below:**

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**15. May CWS share your identity with the local county police department for follow up? Yes \_\_\_ No \_\_\_**

**THANK YOU FOR YOUR ASSISTANCE.**

#### **FOR CWS USE ONLY**

**Disposition:** \_\_\_\_\_

**UNIT** \_\_\_\_\_ **WORKER** \_\_\_\_\_

**ADDITIONAL COMMENTS/NARRATIVE:** Please attach comments/narrative if required or necessary for clarification.